IN THE MATTER OF	*	**BEFORE THE**
RUBEENA HOSAIN, D.M.D.	*	**STATE BOARD OF**
RESPONDENT	*	**DENTAL EXAMINERS**
License Number: 13117	*	**Case Number: 2014-231**

* * * * * * * * * * * * *

CONSENT ORDER

On July 22, 2014, the State Board of Dental Examiners (the "Board") summarily suspended the license of **RUBEENA HOSAIN, D.M.D.** (the "Respondent"), License Number 13117, pursuant to Md. Code Ann., State Gov't ("State Gov't"), § 10-226(c) (2009 Repl. Vol. & 2013 Supp.), concluding that the public health, safety and welfare imperatively required emergency action.[1]

On August 6, 2014, the Board charged the Respondent under the Maryland Dentistry Act (the "Act"), Md. Code Ann., Health Occ. ("Health Occ.") §§ 4-101 et seq. (2009 Repl. Vol. & 2013 Supp.) pursuant to Health Occ. § 4-315(a). The pertinent provisions of Health Occ. § 4-315(a), and those under which the Respondent was charged, are as follows:

> (a) *License to practice dentistry.* – Subject to the hearing provisions of § 4-318 of this subtitle, the Board may deny a general license to practice dentistry...reprimand any licensed dentist, place any licensed dentist on probation, or suspend or revoke the license of any licensed dentist, if the ... licensee:
>
> ...
>
> (16) Behaves dishonorably or unprofessionally, or violates a professional code of ethics pertaining to the dentistry profession;
>
> ...

[1] This Consent Order supersedes the Board's July 22, 2014 Order for Summary Suspension.

(28) Except in an emergency life-threatening situation where it is not feasible or practicable, fails to comply with the Centers for Disease Control's guidelines on universal precautions[.]

The pertinent regulations provide:

Md. Code Regs. 10.52.11:

.03 Compliance Requirements for an Individual.

An individual who is performing patient care activities shall:

A. Comply with the principles of universal precautions;

...

C. Comply with current professional standards of patient care with regard to disinfection and sterilization of reusable devices used in patient care procedures; including:

...

(2) Properly disposing of needles and other sharps devices.

.05 Compliance Requirements for Health Care Professional with Private Professional Office.

A. A health care professional who practices in a private professional office shall:

(1) Ensure that an individual who performs patient care services in the professional's office:

(a) Complies with the principles of universal precautions,

...

(c) Complies with current professional standards of patient care with regard to disinfection and sterilization of reusable devices used in patient care procedures; and

(2) ...[D]isplay the version of the notice "We Take Precautions for You" specified in Table B of this regulation.[2]

...

On August 20, 2014, the Respondent appeared before a Case Resolution Conference Committee ("CRC") to discuss the pending charges and a potential resolution of the charges. Following the CRC, the parties agreed to enter into this Consent Order as a means of resolving this matter.

FINDINGS OF FACT

The Board finds:

1. At all times relevant to these Charges, the Respondent was licensed to practice dentistry in the State of Maryland. The Respondent was initially licensed to practice dentistry in Maryland on or about December 7, 2001, under License Number 13117.

2. On July 22, 2014, the Board summarily suspended the Respondent's license to practice dentistry based on investigative findings that the Respondent had failed to comply with an inspection by an independent infection control consultant ("Board expert") that revealed serious Centers for Disease Control ("CDC") [3] violations of its guidelines for infection control, the results of which are set forth in pertinent part below.

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[2] Table B includes "Dentist."

[3] The Centers for Disease Control and Prevention ("CDC") is a federal agency dedicated to designing protocols to prevent the spread of disease. The CDC has issued guidelines for dental offices which detail the procedures deemed necessary to minimize the chance of transmitting infection both from one patient to another and from the dentist, dental hygienist and dental staff to and from the patients. These guidelines include some very basic precautions, such as washing one's hands prior to and after treating a patient, and also sets forth more involved standards for infection control. Under the Act, all dentists are required to comply with the CDC guidelines which incorporate by reference Occupational Safety and Health Administration's ("OSHA") final rule on Occupational Exposure to Bloodborne Pathogens (29 CFR 1910.1030). The only exception to this rule arises in an emergency which is: 1) life-threatening; and (2) where it is not feasible or practicable to comply with the guidelines.

3. At all times relevant to this Order, the Respondent operated a general dental practice at two sites: the office at issue is located in Towson, Maryland ("Towson office"). The Respondent's second office is located in Pikesville, Maryland.[4] The Respondent is a solo practitioner.

4. The Board initiated an investigation of the Respondent after reviewing a complaint from one of her patients ("Patient A") who was seen in the Towson office location.[5] Patient A alleged in large part, unsanitary conditions of the Respondent's Towson office.

5. The Department of Health and Mental Hygiene and the Board's regulations pursuant to Md. Code Regs. 9.12.31 require compliance with the Occupational Exposure to Bloodborne Pathogens Standard ("BPS"); and pursuant to Md. Code Regs. 10.52.11, CDC Guidelines for Infection Control in Dental Health Care Settings ("ICDHC") referenced in the Universal Infection Control Precautions Standard.

6. On June 24, 2014, the Board expert conducted an unannounced inspection of the Respondent's Towson office to determine whether the Respondent was in compliance with the Maryland Dentistry Act (the "Act") and the CDC guidelines on universal precautions. The Board expert found numerous CDC violations she defined as "multiple safety issues" during the inspection, and opined as to the Respondent's Towson office, "The facility is not a safe and healthy place in which to receive dental care." The Board expert's findings are set forth in pertinent part below.

[4] After the suspension of the Respondent's license, she represented that on the termination of the suspension of her license, she does not intend to resume practice at the Pikesville location.
[5] In order to maintain confidentiality, patient names will not be used in this document, but will be provided to the Respondent on request.

7. On or about July 7, 2014, the Respondent submitted to the Board expert supplemental documentation, photographs of corrections she had made and a note of explanation. Notwithstanding the additional documentation and photographs, the Board expert opined that the Respondent's implementation of safety protocols was inconsistent and reaffirmed the Respondent's office was not a "safe and healthy place to receive dental care."

JUNE 24, 2014 OFFICE INSPECTION

8. The Board expert conducted a three hour inspection of the Towson office, during which time one patient was present and being treated by the Respondent.

9. The Board expert based her analysis of the Respondent's compliance with infection control on direct observation of Respondent using personal protective equipment, preparation of patient care items, protection/disinfection of environmental surfaces, and sterilization of reusable instruments at the Towson office, as well as discussions with the Respondent.

10. The Respondent has one employee at the Towson office; however, on the date of the inspection, he (the employee) was not present. The employee does not engage in patient care; he is responsible for working at the front desk, preparing instruments for sterilization and performing general office cleaning.

11. The Respondent's Towson office consists of a reception area with an adjacent business office, two active treatment rooms, an instrument preparatory alcove and a sterilization area. Two operatories have been converted into a staff lounge and private office, respectively, and are not used for treatment purposes. Lastly, a storage

closet is in the clinic area, and additionally, there is a second private office and a bathroom.

12. The Board expert issued a June 27, 2014 report summarizing her findings during the inspection:

A. STANDARD PRECAUTIONS AND PERSONAL PROTECTIVE EQUIPMENT

a. The overall presentation of the treatment and instrument preparation rooms was of "clutter and disorganization";
b. Cabinets and countertops had visible stains and soiled areas;
c. The floors were carpeted with worn and soiled areas;
d. Various LEGO[6] structures in varying degrees of completion were displayed throughout the office and those in the treatment rooms were dusty;
e. The Respondent was unable to provide recordkeeping to the Board expert for a Health and Safety Program (including an Exposure Control Plan), employee Hepatitis B vaccination records, clinic maintenance, or any documents relating to infection control compliance;
f. The Respondent failed to post the required "We Take Precautions for You" poster[7] or the Board Radiation Machine facility registration;
g. The Respondent failed to post and was unable to produce a current dental license;[8]
h. There was no alcohol hand sanitizer present;
i. The Respondent failed to wash her hands with soap and water during the Board expert's three hour visit;[9]
j. The Respondent wore used treatment gloves while walking around the office during the inspection;
k. The Respondent required "prompts" from the Board expert to wear utility gloves during instrument preparation, and the gloves were worn and damaged;
l. During the three hour visit, the Respondent failed to change her used mask until prompted by the Board expert;
m. Spare laboratory coats hanging in the office appeared to have been worn, and not subsequently cleaned. The Respondent was unable to provide information regarding a laundry service used by the Towson office; and

[6] A brand name for a popular line of construction toys.
[7] Md. Code Regs. 10.52.11.04A(2) requires that the notice be posted at the entrance to the health care facility.
[8] Md. Code Ann., Health Occ. § 4-313(b).
[9] BPS requires handwashing before and after glove use.

n. The Respondent, who wore prescription eyewear, failed to have side shields on her glasses during patient treatment. The Respondent was able to verbally provide to the Board expert the protocol for rinsing the eyes after exposure, but was unable to produce the written protocol.

B. STERILIZATION PROTOCOL[10]

a. The Respondent failed to establish a protocol to remove dental handpieces from the dental unit after each patient and verifiably sterilize them;
b. The Respondent failed to verifiably sterilize the reusable instruments and burs[11] in the general treatment area;
c. The Respondent failed to establish an event-related protocol for the use of bagged instruments;
d. The Respondent has been reusing sterilization bags, rendering the process monitors ineffective;
e. The Respondent did not have any new unused sterilization bags in the office during the inspection; and
f. Although there was a note on the autoclave reflecting that a spore test was scheduled to be run on the following Monday, the Respondent was unable to produce records for weekly spore testing to evaluate the effectiveness of the heat source.[12]

C. TREATMENT ROOM DISINFECTION AND CROSS CONTAMINATION PREVENTION

a. Re-usable instruments that the Respondent stored in drawers and cabinets were not consistently sealed in intact sterilization bags with activated process monitors;
b. A stockpile of disposable mouth mirrors were located in treatment room cabinets. Many of the mouth mirrors appeared to have been used;
c. Although the Respondent had a protocol in place for barrier protection and surface decontamination, and barriers were removed after each patient, prompts from the Board expert were necessary for this to occur; and
d. The Respondent uses a countertop in the operatory to document in patient charts potentiating cross contamination.

D. SHARPS MANAGEMENT AND REGULATED/BIOHARZADOUS WASTE DISPOSAL

[10] Md. Code Regs. 10.52.11.03(c) and 10.52.11.04(1)(c) require care with regard to disinfection and sterilization of reusable devices used in patient care procedures.
[11] Type of cutter used in a handpiece for cutting hard tissue such as tooth or bone.
[12] The standard requires weekly records for a minimum of three years.

a. A small red medical waste bag was overfilled in a cabinet under the autoclave;[13]
b. The single sharps container was overfilled; and
c. The Respondent was unable to produce the required recordkeeping for infectious/medical waste.

E. DENTAL UNIT WATERLINE POLICY

a. The Respondent failed to establish a Dental Unit Waterline Policy as required by CDC guidelines for ICDHS.

F. RADIATION SAFETY[14]

a. The Radiation Machine Facility Registration was not available in the Towson office;
b. The Respondent was unable to adequately produce dosimetry tests;
c. The Respondent was unable to produce calibration or inspection certificates for the Towson office; and
d. The Respondent was unable to produce a written protocol for disposal of lead foils and processing chemicals.

G. FIRST AID, EMERGENCY PROCEDURES AND EXPIRATION DATES

a. There was no emergency evacuation plan available for the Towson office;
b. There was no written policy for Managing Occupational Exposure to BPS; and
c. There was no Cardiopulmonary Resuscitation ("CPR") mask available in the Towson office.

JULY 3, 2014 ADDENDUM TO THE BOARD EXPERT REPORT

13. Subsequent to the June 24, 2014 inspection, the Respondent provided the following documents to the Board expert:

a. A copy of the Respondent's current dental license;

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[13] The standard is that all disposable items saturated with blood or saliva, and/or caked with dried blood/saliva should be disposed of in a regulated biohazardous waste container. Additionally, the CDC/ICDHS (Infection Control in Dental Health-Care Settings) states: "Dental health care facilities should dispose of medical waste regularly to avoid accumulation." The small red medical waste bag did not meet the standard to contain medical waste. Md. Code Regs. 10.52.11.03C(2) requires proper disposal of needles and other sharps devices.

[14] Md. Code Regs. 26.12.01.01 et seq.

b. Evidence of continuing education in infection control including one credit for 2012 and 13 credits for 2005-2008;
c. May 2012 through April 2013 and May 1, 2013 through June 17, 2014 documentation of sterilization monitoring (spore testing);
d. April 2, 2009 and November 8, 2012 documentation of biological waste disposal;
e. Documentation of radiation detection service from September 27, 2012 through April 18, 2013; and
f. June 30, 2014 declination of Hepatitis B vaccination by employee.

14. The Respondent also submitted photographs reflecting the following:

a. That she had subsequently posted in her Towson office the Board mandated "We Take Precautions for You" poster and the radiation machine facility registration;
b. That the Respondent placed new unused sterilization bags in the sterilization alcove;
c. Operatory countertops and cabinets appear to have been cleaned and drawers reorganized;
d. Re-usable instruments stored in the drawers appear to have been sealed in intact sterilization bags; and
e. Development of a new sharps container preparatory alcove. The area appears clean and organized.

15. After reviewing the additional documents and photographs submitted by the Respondent noted in ¶¶13 and 14, the Board expert filed an addendum to her initial report. The Board expert opined that with the additional submissions, the following "serious violations to the Occupational Exposure to [BPS]...and CDC Guidelines for [ICDHS] referenced in the Universal Infection Control Precautions Standard..." remained in the Towson office:

a. Lacked written records for annual safety evaluation;
b. No written Exposure Control Plan with safety protocols;
c. No employee training records for at least the prior three years;
d. No Hepatitis B vaccination records for the Respondent and any prior employees;
e. No written post-exposure protocol;
f. The Respondent wore used treatment gloves while walking around the office during the June 24, 2014 inspection;
g. The Respondent re-used sterilization bags as viewed during the June 24, 2014 inspection;

h. The Respondent did not promptly process instruments after use as viewed during the June 24, 2014 inspection;
i. The medical waste container was undersized, overfilled and located in the "clean" sterilization area inside a cabinet with poor access as viewed during the June 24, 2014 inspection;
j. The office lacked consistent, verifiable sterilization of all re-usable intra-oral instruments including high and low handpieces, ultrasonic scalers, burs and some hand instruments;
k. The disposable mouth mirrors appeared to have been re-used as viewed during the June 24, 2014 inspection;
l. dental unit waterline maintenance policy is not established;
m. Lacked three years of continuous biohazardous waste manifests showing regular medical waste removal and/or safe processing;
n. The Respondent failed to dispose of sharps in a proper and timely manner as viewed during the June 24, 2014 inspection;
o. A CPR mask was not available; and
p. Multiple medical emergency supplies had expired.

16. Additionally, on inspection, the Respondent was unable to produce calibration and inspection documentation for her radiographic equipment.

CONCLUSIONS OF LAW

Based on the foregoing Findings of Fact, the Board concludes as a matter of law that the Respondent failed to comply with Centers for Disease Control's guidelines on universal precautions, in violation of H.O. § 4-315(a)(28). The Board agrees to dismiss the charges under H.O. § 4-315(a)(16).

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, it is this 25th day of August, 2014, by a majority of the quorum of the Board, hereby

ORDERED that having received a favorable CDC inspection report dated August 19, 2014 of the Respondent's Towson office location by a Board-approved CDC

inspector,[15] [16] the **SUSPENSION** of the Respondent's license to practice dentistry is lifted and she is hereby placed on a minimum of **TWO (2) YEARS OF PROBATION** under the following terms and conditions:

1. Within **TWO (2) WEEKS** from the date the suspension is lifted, the Respondent shall have a Board-approved consultant evaluate her current dental office for compliance with CDC guidelines during a full day of patient care, consisting of two (2) to five (5) patients;

2. Within **FOUR (4) MONTHS** of the date the Suspension is lifted, a Board-approved consultant shall conduct an unannounced inspection to re-evaluate the Respondent's current dental office for compliance with CDC guidelines and to train the Respondent and each employee of the office in applying the CDC guidelines to the dental practice;

3. Within **FIVE (5)** days of the date of this Consent Order, the Respondent shall provide the Board with evidence that she is no longer practicing dentistry at the Pikesville location;

4. The Respondent shall notify the Board prior to changing the location of her practice or adding any practice location, in order for the Board to modify or amend this Consent Order to require any necessary terms or conditions including but not limited to pre-opening the practice and random inspections;

5. The Respondent shall provide to the Board, on or before the fifth (5^{th}) day of each month, a listing of her regularly scheduled days and hours for patient care for each office where the Respondent practices dentistry;

6. The Respondent shall be subject to an additional three (3) inspections by the consultant, or other Board-approved agent, during her probationary period the last three being unannounced inspections. These inspections shall be of all offices where the Respondent practices dentistry. The Respondent shall request that the consultant provide reports to the Board within ten (10) days of the date of the inspection. The

[15] The Board-approved CDC inspector's report was subsequently reviewed and approved by the Board.
[16] At all times relevant to the charges and summary suspension in this case, the Respondent practiced at two locations. This Consent Order is intended to encompass any and all practices at which the Respondent practices. Based on the Respondent's representation that she has ceased practicing at the Pikesville office and plans to maintain only the Towson location, the terms and conditions of the Order apply to the Towson location. Any modification to the location of the Respondent's practice shall require notice to the Board and a modification to this Consent Order.

consultant may consult with the Board regarding the findings of the inspections;

7. Based on unannounced inspections, if the Board makes a finding that Respondent is not in compliance with CDC guidelines in any office where the Respondent practices dentistry, it shall constitute a violation of this Consent Order, and it may, in the Board's discretion, be grounds for immediately suspending Respondent's license. In the event that Respondent's license is suspended under this provision, she shall be afforded a Show Cause Hearing before the Board to show cause as to why her license should not be suspended or should not have been suspended.

8. Within six (6) months of this Consent Order, the Respondent shall complete a Board-approved infection control course. The course shall not be applied to her required continuing education credits required for continued licensure;

9. The Respondent shall complete all required continuing education courses required for renewal of his license. No part of the training or education that she receives in compliance with this Consent Order shall be applied to her required continuing education credits;

10. The Respondent shall comply with CDC guidelines, including Occupational Safety and Health Administration's ("OSHA") for dental healthcare settings;

11. The Respondent shall be responsible for all costs associated with fulfilling the terms of the Consent Order;

12. The Respondent shall practice according to the Maryland Dentistry Act and in accordance with all applicable laws; and be it further

ORDERED that any violation of the terms or conditions of this Consent Order shall be deemed a violation of this Consent Order; and be it further

ORDERED that if Respondent violates any of the terms or conditions of this Consent Order, the Board, in its discretion, after notice and an opportunity for an evidentiary hearing before the Board, may impose any sanction which the Board may have imposed in this case under §§ 4-315 and 4-317 of the Dental Practice Act, including additional probationary terms and conditions, reprimand, suspension,

revocation and/or a monetary penalty, said violation of probation being proved by a preponderance of the evidence; and be it further

ORDERED that after a minimum of **TWO (2) YEARS OF PROBATION**, Respondent may submit a written petition to the Board requesting termination of probation. After consideration of the petition, the probation may be terminated through an order of the Board. The Board will grant the termination if Respondent has fully and satisfactorily complied with all of the probationary terms and conditions and there are no pending complaints related to the charges; and be it further

ORDERED that this Consent Order is a **PUBLIC DOCUMENT** pursuant to Md. State Gov't Code Ann. § 10-601 *et seq.* (2009 Repl. Vol. & 2013 Supp.).

Maurice Miles DDS

Maurice S. Miles, D.D.S., President
Maryland State Board of Dental Examiners

CONSENT

I, Rubeena Hosain, D.M.D., acknowledge that I am represented by counsel and have consulted with counsel before entering this Consent Order. By this Consent and for the purpose of resolving the issues raised by the Board, I agree and accept to be bound by the foregoing Consent Order and its conditions.

I acknowledge the validity of this Consent Order as if entered into after the conclusion of a formal evidentiary hearing in which I would have had the right to counsel, to confront witnesses, to give testimony, to call witnesses on my own behalf, and to all other substantive and procedural protections provided by the law. I agree to forego my opportunity to challenge these allegations. I acknowledge the legal authority

and jurisdiction of the Board to initiate these proceedings and to issue and enforce this Consent Order. I affirm that I am waiving my right to appeal any adverse ruling of the Board that I might have filed after any such hearing.

I sign this Consent Order after having an opportunity to consult with counsel, voluntarily and without reservation, and I fully understand and comprehend the language, meaning and terms of the Consent Order.

8-21-14
Date

R Hosain
Rubeena Hosain, D.M.D.
Respondent

Reviewed by:

Mary Keating
Mary Keating, Esquire

STATE OF Maryland

CITY/COUNTY OF Baltimore

I HEREBY CERTIFY that on this 21st day of August 2014, before me, a Notary Public of the foregoing State and City/County, Rubeena Hosain, D.M.D. personally appeared , and made oath in due form of law that signing the foregoing Consent Order was her voluntary act and deed.

AS WITNESSETH my hand and notarial seal.

Mary T Keating
Notary Public

My Commission expires: 3-3-2017